

TABLE 1.—Results of Antigen Testing with Bee-Collected Almond Pollen and Anthers

| Intradermal Test | Dilution | 5 Min-utes | 15 Min-utes | 30 Min-utes | 48-Hour Induration |
|----------------------|----------|------------|-------------|-------------|--------------------|
| Pollen | 1:1000 | 2+ | 2+ | 2+ | 2 cm. |
| Pollen and anthers.. | 1:1000* | 4+ | 4+ | 4+ | 4 cm. |
| Pollen | 1:1000* | 4+ | 4+ | 4+ | 1 cm. |
| Scratch test | | | | | |
| Pollen | 1:100 | 2+ | | 2+ | |
| Pollen and anthers.. | 1:10 | 1+ | | 1+ | |
| Pollen | 1:20 | 4+ | | 4+ | |

*Massive pseudopodia were produced.

weight; and desensitizing doses, by that time in a dilution of 1:10, were discontinued. Symptoms did not recur during the 1958 almond pollination season.

DISCUSSION

The method of obtaining pollen for testing in this case—by bee collection—may be considered in future preparation of regional antigens. The collection was obtained at Davis under well-controlled conditions during a season when other possible allergens—grasses and tree pollens—were dormant. The antigen was highly specific, representing probably no more than two out of the 45 varieties of almond grown in California. A number of other patients with respiratory tract allergic disease due to inhalant pollens have been tested with this material but without response.

Practically all the commercial almond orchards in the United States are in California. They cover approximately 88,000 acres, with Butte County having the largest acreage.

SUMMARY

A case of respiratory tract allergic reaction to almond pollen, successfully treated by desensitizing doses of the pollen, is reported. This is apparently the first reported case of sensitivity to the pollen of almond trees.

Honey bees were used to collect the pollen that was used for testing and desensitization.

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Palmar Intramural Thrombosis In the Ulnar Artery

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THE PROBLEM of pain in the hand has many origins and may be baffling. The cause may be local or distal. It may be due to trauma, infection or tumors, or to reflex changes from the chest, neck, brachial plexus, shoulder, elbow or wrist.

REPORT OF A CASE

In the present case the patient was a 37-year-old man who sought medical advice on October 7, 1957, because of a "ganglion" that had developed in the hypothenar area of the left hand while he was at work about three weeks previously. As a warehouseman, he frequently pounded with the palm of his left hand over the top of a screwdriver to open cases of merchandise. Soon after the "ganglion" appeared, prickling sensations developed in the palm of the left hand and the left little and ring fingers. In addition the patient noticed a feeling of coldness and pain in those fingers. The pain in the hand increased about a week before he was seen by the author.

The patient had had herniotomy in 1950. He had had no other illnesses, vascular disturbances or neurological disturbances before the onset of pain in the hand.

Upon examination, tenderness, coldness and blanching of the left little and ring fingers was noted, indicating impairment of vascular supply. A fluctuating firm nodular mass was palpated over the hypothenar area of the left hand. Putting pressure on the midpalmar area caused pain and tingling in the left little and ring fingers. Sensation to pinprick and touch was unimpaired. No evidence of pathologic change in the bones or joints of the left hand was seen in x-ray films.

In view of the coldness and blanching of the ring and little fingers of the hand, ulnar nerve block to remove any nerve irritation was done by injecting 1 per cent procaine solution into the ulnar notch at the elbow. This procedure did not alleviate the vasospastic blanching and coldness of the fingers, although there was some diminution of sensation. Five cubic centimeters of 1 per cent procaine solution was also injected in the tender area in the palm, without improvement in the coldness and blanching of the skin of the ring and little fingers. The next day a cervical sympathetic nerve block was carried out by injecting 30 cc. of 1 per cent procaine solution. Enophthalmos and dryness of the skin on the left side of the face occurred immediately, and there was an increase in the temperature of the left upper extremity and fingers, except for the little and ring fingers, which were only partially improved.

Presented before the Section on Orthopedics at the 87th Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1958.

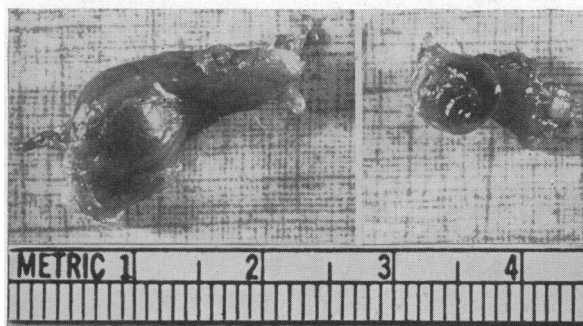


Figure 1.—*Left*, resected ulnar artery with bulge at site of intramural hematoma. *Right*, cross-section at site of bulge, showing eccentric lumen.

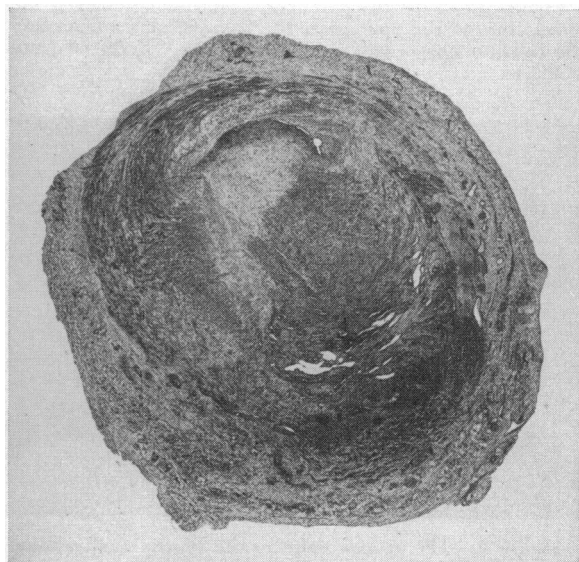


Figure 2.—Microscopic cross-section of ulnar artery, showing eccentric lumen and intramural hematoma.

The patient was then admitted to hospital for an exploration of the hypothenar area and the ganglion-like nodule there. General anesthesia was given, and a tourniquet was applied to control bleeding. A curved incision was made over the hypothenar area and the fascia and underlying muscles, vessels and nerves were exposed. The ulnar artery and nerve were in a normal position. Owing to pronounced dilatation and deformity, the ulnar artery was partially protruding through the overstretched hypothenar fascia. There were several bands of adhesions between the ulnar artery and the adjacent ulnar nerve. The ulnar nerve was movable and free of any bruising. In situ the ulnar artery at its greatest width was about 1.3 cm. in diameter, and it did not pulsate after the tourniquet was removed. It was nodular and seemed to be of cyst-like structure, which was marble-like in consistency over the site of the greatest dilatation. The ulnar artery in the palm was ligated on both sides of the node, which was then excised (Figure 1). The wound was then closed in layers and the hand immobilized in a splint for seven days. After whirlpool treatments and physio-

therapy, the patient returned to his usual occupation three weeks later, all symptoms of vascular impairment in the fingers having abated.

PATHOLOGIST'S REPORT

The specimen was a section of blood vessel 2 cm. long. The diameter was 0.2 cm. at both ends, with a bulge to 0.5 cm. in the mid portion (Figure 1). The vessel and nodule were covered by connective tissue. The cut surface showed a patent lumen with an eccentrically placed organized clot within the wall of the vessel.

Microscopically observed in a cross-section of the vessel at the expanded part was an organizing thrombus with a fibrinoid clot superimposed, occluding the lumen (Figure 2). No abnormality was noted in sections of the artery distal to the enlargement. The deeper sections showed what appeared to be disruption of the internal elastic lamella with extension of the thrombus into the wall of the artery. The diagnosis was "thrombus of an artery."

SUMMARY

A case is presented in which a palmar intramural thrombus of the ulnar artery caused reflex vasospasm and pain in the adjacent ring and little fingers. The condition was easily corrected surgically.

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Bowen's Disease of the Anus

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In 1912¹ and in 1915² Bowen described, under the title of "Precancerous Dermatoses," a type of intra-epidermal squamous cell epithelioma which has subsequently borne his name. Reports of six cases of Bowen's disease of the anus were found in a review of the literature since 1942.^{4,5,7,8} There is some controversy as to whether Bowen's disease is a distinct kind of skin disease or is the same as carcinoma in situ. Some investigators^{3,9,12} hold that Bowen's disease is a true primary epithelial neoplasm, others^{13,14} disagree. The rarity of this condition in the anal region, and the authors' opinion that Bowen's disease is a true primary epithelial neoplasm prompted the following case report.

CASE REPORT

The patient, a 50-year-old married white woman, was admitted to St. Mary's Hospital with chief complaint of itching and burning in the anal area of eight years' duration. For some six months she had noted small amounts of blood on the toilet paper and burning pain after defecation.

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Submitted July 24, 1958.